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ABSTRACT

A pilot program was designed to address the special problems of children of substance abusers. The program was established at the Child Development and Family Guidance Center by Operation PAR, a nationally recognized substance abuse treatment and prevention program. The staff are well-trained preschool professionals who have received special training in substance abuse prevention by Operation PAR. Children, primarily preschoolers, are enrolled in the center after case managers have admitted the abusing parent to case management services. Screening with the Hawaii Early Learning Profile (HELP) has shown that the center children tend to exhibit delays in fine motor development, language development, and social skills. They also have emotional and physical care needs. A typical preschool program was modified to allow for the children's developmental stages. In view of the children's lack of a stable adult relationship, center staff decided that their initial goals when dealing with the children would be to provide patience, love, and acceptance. Typical characteristics of the children include withdrawn and fearful behaviors; temper tantrums; frequent colds, coughs, and fevers; and scabies, head lice, impetigo, and ring worms. It is difficult to involve parents in their child's preschool experience and to encourage them to get the immunizations needed for their children. (RJC)

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A Unique Program for Preschool Children of Substance Abusers

Presented to the Southern Association
on Children Under Six
April 13-16, 1989
Richmond, Va.

by

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"Flattops," yells a four-year-old. "Fire in the hole!"

"Freeze, buster," screams another four-year-old. "Police. Don't move."

While pretend play sessions such as these are not yet common in small-town preschools and child care centers, they are becoming increasingly common in centers located in large cities. Those fluent in the jargon of drug abuse would recognize the above scenario as the first youngster alerting a crack cocaine house occupants of the arrival of the police, represented by the second youngster. Even those less attuned to the drug culture understand, as did the executive director of an inner-city child care center, when three-year-olds pretend to be sniffing cocaine (Evelyn Motley, personal conversation, 30 July 1988). Such situations reflect the prevalent use and abuse of drugs in our society and the alarming extension of that drug culture into younger and younger age groups. And they underscore the urgent need for recognition of and assistance to children of substance abusers. Of special concern are "cocaine kids," those youngsters affected physically by crack and crack cocaine in utero, and those who suffer the emotional ravages of growing up in a home where crack is common.

"Cocaine kids" are a recently-identified phenomenon, but their ranks are increasing as quickly as the ranks of crack addicts. In Florida alone, it is estimated that in 1989 12,000 babies will be born addicted to cocaine (St.

Petersburg Times, 15 February 1989). Until recently, few alternatives existed for "cocaine kids." Now, a pilot program in St. Petersburg, FL, is testing the concept of intervening with preschool children of substance abusers. The pilot program, combining a child care center and case management of the abusing parents, is funded primarily by the Federal Office of Substance Abuse Prevention. The program is innovative and one of the first in the country to address the problem of substance abuse from a perspective other than treatment of the substance abuser. Historically, federal and state funding agency service guidelines and insurance industry standards have led to treatment focused on the abuser.

The demonstration grant program in St. Petersburg recognizes that the preschool child of an abuser - no matter what the drug abused - must contend with a host of problems related to parental chemical dependency. Children of substance abusers suffer physical, emotional, mental and developmental problems as a result of parental drug abuse during pregnancy, for example. Fetal alcohol syndrome (FAS), which results from a mother's abuse of alcohol during pregnancy, is now considered the third most common cause of mental deficiency (Sharp and Turney, 1984). More than 3,700 American infants each year are born with FAS (National Center for Clinical Infant Programs, 1986). However, even Fetal Alcohol Syndrome has taken a back seat to the problems of children born addicted because their mothers used cocaine

while pregnant. These babies suffer immediate effects of their mothers' cocaine use for up to three months after birth, but the problem is so new that experts can't even predict the longterm effects. Dr. Ira Chasnoff, director of the Perinatal Center for Chemical Dependency at Northwestern University Medical School, is one of the first in this country to begin studying "cocaine babies." At a conference in February 1988 in Clearwater, FL, and in an earlier journal article (Chasnoff, 1987), he noted that data are still insufficient to analyze developmental outcome of cocaine-addicted babies, but that these children must be considered at high risk for developmental and learning disabilities. As well, these children must cope with the problems associated with low birth weight, smaller head circumference, the effects of premature deliveries and serious health problems such as strokes, limb deformities and seizures. In this author's city alone, it is estimated that one in ten babies are born cocaine-addicted (Coletti, 1987). And the number of babies born addicted nationally grows as health personnel become more familiar with the signs of neonatal addiction and institute screening procedures.

The child who lives with a substance-abusing parent frequently fares no better emotionally than he may physically or mentally. Children in families where alcohol is a problem generally are ignored while attention is directed toward the chemically dependent parent (Sharp and

Turney, 1984). As well, children of alcoholics are unable to establish primary relationships outside the home (Ackerman, 1983). Children of drug-dependent women often suffer from emotional neglect, family instability, lack of positive adult role models and lack of peer relationships. And children of substance-abusers are at risk for potential abuse, poor parenting practices and future drug use (Beschner et. al., 1981).

The pilot program designed to address the special problems of children of substance abusers was established as the Child Development and Family Guidance Center by Operation PAR, a nationally-recognized substance abuse treatment and prevention program. In 1986, Operation PAR was named the country's outstanding program by the Alcohol and Drug Problems Association of North America. PAR located a motel that was renovated for the pilot program. The center is located across the street from an idyllic city park lake, and just blocks from "Crackdown '89," a police attempt to crack down on crack.

The center has two preschool classrooms and a child care services supervisor's office located on one side of a courtyard playground, an infant center in the rear, and case management offices near the front and other side. A director oversees the program, while a program coordinator works primarily with the case managers and the child care services supervisor works primarily with the teachers and teacher aides.

The child care center began admitting children in June, 1988. The children are enrolled after case managers have admitted the abusing parent to case management services. The center's funding parameters called for a maximum enrollment of three infants 2 months to 2 years old, 10 two- and three-year-olds, and 12 late three-year-olds to five-year-olds. Recently, responding to the need for increased services to children of substance abusers, the Juvenile Welfare Board of Pinellas County provided funds for Operation PAR to add six more infants on site and 14 in day care homes in conjunction with Project Playpen. Project Playpen provides subsidized child care services in Pinellas County. The Child Development and Family Guidance Center is staffed by three teachers and three teacher's assistants, in addition to the child care services supervisor and a housekeeper/cook. The center is open 7:30 a.m. to 5:30 p.m. weekdays. The center transports most of its children.

The center staff are well-trained preschool professionals. But, having little or no knowledge of substance abuse prevention, they are schooled in that area by Operation PAR. As well, staff undertake outside training on their own. As a result, all are to have at least 40 hours of inservice training in addition to their preschool education and experience. Despite the extensive preparation and professional backgrounds, staff were not certain exactly how to best prepare for the needs of children of substance abusers, since little or no information has been available

on the subject. For example, staff were not certain if these children would exhibit serious developmental delays or deficits, although they strongly suspected that in many areas these children would need intensive effort. As well, planning a curriculum proved highly speculative since the nature and extent of the children's needs would not be known until assessment upon enrollment.

The staff decided to rely upon their belief that children enrolled in the program might be excitable due to an unstable home environment. So they chose an environment that downplayed the typical primary colors with a muted soft gray background. They wisely postponed major curriculum decisions until after working with the children for several weeks so as not to implement a program that was beyond the children's capabilities. Staff wanted to be certain they allowed success for children whose lives might previously have been devoid of accomplishment.

As well, staff lobbied against typical "testing" of children for fear the children would be "labeled" and live with that label for years to come. Based upon the advice of Dr. Nicholas Anastasiow, professor of early childhood education, Hunter College of the City University of New York, the center chose the Hawaii Early Learning Profile (HELP) for assessing children's developmental status. The HELP measures developmental progress in incremental steps. Finally, staff believed that children enrolled in the program would suffer from the lack of a stable adult

relationship and decided that the staff's most important initial goals when dealing with the children would be patience, love and acceptance.

After a year of operation, staff are discovering their initial beliefs are holding true. And they are learning many important things about children who come from homes where substance abuse is a problem. Some of the preschoolers are are withdrawn and fearful. Some find their chief expression in temper tantrums. Interestingly, while temper is a problem, these children thus far have exhibited little aggression, directing their frustration inward rather than toward others. Screening with the Hawaii Early Learning Profile has shown that the children enrolled in the center tend to exhibit delays in fine motor development, language development and social skills. Even informal observation led teachers early on to remove typical materials from their classrooms in favor of scaled-down, simpler teaching materials.

Children's health problems and concerns resulted in a physician from the county health department providing medical assistance one day a week, and setting up streamlined procedures for getting children's parents in and out of the department for treatment. Teachers have noted frequent colds, coughs and fever, and are quite adept at recognizing scabies, head lice, impetigo and ring worm due to their frequency among the children.

Many of the center's children are in foster homes after being removed from the care of a drug-abusing mother. Staff move quickly to meet the needs of the enrolled children, including feeding, bathing and finding clothes for the family of four who, removed from their mother three days before Christmas, were brought to the center prior to foster care placement because the center was the one stable place the children knew. Staff spend their own money when they think it will benefit the children, and they always keep their arms open for hugs.

In terms of curriculum, teachers decided to utilize a typical preschool plan but quickly modified that to allow for the children's developmental stages. In the first few months of program operation, days were arranged around activities rather than formal plans with their designated circle times and open learning periods. As children and teachers became familiar with each other, a more noticeable and definitive curriculum approach occurred. Still, teachers allow for the inevitable circle time sharing that brings forth comments about "bullets hitting my front door last night" and discussion of mommy's boyfriend hitting her because he was mad.

Some of the infants enrolled in the Child Development Center do fit problem parameters outlined by Dr. Chasnoff. Many of them have frequent colds and runny noses. One

infant exhibited significant enough signs of motor delays that the county health physician referred him to his private physician for further diagnosis.

It should be noted that, as might be expected, the parents of the children enrolled in the center do not fit the typical parameters of a preschooler's parent. It is difficult to get them involved in their child's preschool experience. And when faced with the necessity of an immunization for their child, they are just as likely to remove the child from school for several days to weeks than face the hassle of taking the child for the immunization. Many of the parents move frequently, making it difficult for center personnel to maintain records or check on medical followups. These parents often need help with clothing, shelter, food and other basic necessities of just getting by, and center personnel are aware that these basic needs often pre-empt concern for their children.

One specific roadblock presented by at least one parent of a child enrolled in the center is the attitude that, because she admitted use of cocaine during pregnancy, her admission meant everything ought to be okay from now on. She was unwilling to acknowledge that her child, even at 5 months, might still be suffering from her previous drug use, and that he might continue to exhibit problems for years to come. Other parents, however, learn through case management services that their responsibility continues past abstinence from drugs.

There are success stories to be told from the initial year's operation. Perhaps the happiest is that of Jartrane. When 4-year-old Jartrane - bow-legged, foster child, seeing the world through thick glasses - came to the Child Development and Family Guidance Center, he was fearful and reticent. Hours later, when his foster father came to pick him up, he cried because he didn't want to leave. Last Christmas, Jartrane was adopted by his fraternal grandmother, with whom his teacher spent time to make Jartrane's transition a happy one. Jartrane has had surgery to correct his eyesight problem, and he no longer wears glasses. Jartrane still needs some neurological assessment, but his teacher and center staff remark on his more positive outlook and decreased temper tantrums and outbursts. At a time when society is wondering what to do about "cocaine kids," Jartrane is proof that intervention to the preschool children of substance abusers can pay off, if only in small successes. And the chance of larger successes due to such a program is captivating enough to inspire anyone who believes "cocaine kids" need more than just a label.

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